U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 06 October 2006

CASE NO. 2003-BLA-6256

In the Matter of

L.J., Widow of
S.D.J.,
Claimant

v.

ALLEGHENY MINERAL CORPORATION,
Employer

and

ROCKWOOD INSURANCE COMPANY,
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:

Heath M. Long, Esquire
For the Claimant

Sean B. Epstein, Esquire
For the Employer/Carrier

Before: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a claim for benefits filed by L.J., the surviving spouse of S.D.J., a deceased coal miner, under the Black Lung Benefits Act, 30 U.S.C. §901, *et seq.*

Regulations implementing the Act have been published by the Secretary of Labor in Title 20 of the Code of Federal Regulations.[1]

Black lung benefits are awarded to coal miners who are totally disabled by pneumoconiosis caused by inhalation of harmful dust in the course of coal mine employment and to the surviving dependents of coal miners whose death was caused by pneumoconiosis. Coal workers' pneumoconiosis is commonly known as black lung disease.

A formal hearing was held before the undersigned on March 1, 2006, in Dubois, Pennsylvania. At that time, all parties were afforded full opportunity present evidence and argument as provided in the Act and the regulations issued. Furthermore, the record was held open for the submission of Dr. Kaplan's deposition transcript and post-hearing briefs. The briefs were to be postmarked no later than April 14, 2006 (TR 21-22). The deposition transcript of Dr. Kaplan was submitted under cover letter, dated March 8, 2006, and has been marked and received as Employer's Exhibit 2 (EX 2).

At the hearing, Claimant's counsel withdrew Claimant's Exhibit 6, because it was a duplicate copy of Dr. Schaaf's curriculum vitae, which is already in evidence as Claimant's Exhibit 2 (CX 2). (TR 7-8). In addition, Claimant's counsel redacted Dr. Luderer's report, dated November 19, 2002, from Director's Exhibit 7, since it exceeded the evidentiary limitations of the new regulations (TR 10). Upon review, I note that Director's Exhibit 12 consists of another copy of Dr. Luderer's report, dated November 19, 2002. Since Claimant has already submitted the medical opinions of two other physicians (*i.e.,* Drs. Schaaf and Begley), I, again, find that Dr. Luderer's report is excessive. Therefore, I have also excluded Director's Exhibit 12 from evidence.[2]

In summary, the record consists of the hearing transcript, Director's Exhibits 1 through 31, except Director's Exhibit 12 (DX 1-11, 13-31), Claimant's Exhibits 1 through 10, except Claimant's Exhibit 6 (CX 1-5, 7-10), and Employer's Exhibits 1 and 2 (EX 1-2). The above-listed evidence are all subject to the evidentiary limitations set forth in the new regulations.

The findings of fact and conclusions of law which follow are based upon my analysis of the entire record, including all documentary evidence admitted, testimony presented, and arguments made. Where pertinent, I have made credibility determinations concerning the evidence.

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[1] The Secretary of Labor adopted amendments to the "Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969" as set forth in Federal Register/Vol. 65, No. 245 Wednesday, December 20, 2000. The revised Part 718 regulations became effective on January 19, 2001. Since the current claim was filed on September 12, 2002 (DX 3), the new regulations are applicable (DX 31).

[2] Assuming *arguendo* that Dr. Luderer's report, dated November 19, 2002, had been admitted in evidence, I would accord it little weight, despite his status as a treating physician. In making this determination, I note that Dr. Luderer only provided cursory responses to form questions. Moreover, Dr. Luderer failed to provide any rationale for his conclusion that pneumoconiosis contributed to or played a hastening role in the miner's death (DX 12).

PROCEDURAL HISTORY

On September 12, 2002, Claimant, L.J., the surviving spouse of S.D.J., a deceased coal miner, filed the current application for black lung benefits under the Act (DX 3). On March 27, 2003, the District Director issued a Proposed Decision and Order awarding benefits (DX 23). Following Employer's timely request for a formal hearing (DX 25), this matter was referred to the Office of Administrative Law Judges for adjudication (DX 28-31). I was assigned the case on October 17, 2005. As previously stated, a formal hearing was held on March 1, 2006, and the record was held open until April 14, 2006 (TR 22).[3]

ISSUES

I. Whether the miner had pneumoconiosis as defined by the Act and the regulations?
II. Whether the miner's pneumoconiosis arose out of coal mine employment?
III. Whether the miner's death was due to pneumoconiosis?

(DX 28, as amended; TR 6-7).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

I. Preliminary Ruling

As noted, the miner was receiving Federal black lung benefits prior to his death (DX 1; CX 1; CX 10, Deposition Exhibit 1; TR 13). Therefore, the miner had established the presence of pneumoconiosis arising out of his coal mine employment and total disability due to pneumoconiosis.

In *Collins v. Pond Creek Mining Co.*, 22 BLR 1-230, Case No. 02-0329 BLA (Jan. 28, 2003), the Benefits Review Board held that, generally, an employer is collaterally estopped from re-litigating the issue of whether pneumoconiosis is present if (1) there is a prior decision awarding benefits in a miner's claim, and (2) no autopsy is performed in the survivor's claim. However, the Board upheld that Administrative Law Judge's denial of the application of benefits where, "the miner…was awarded benefits on February 25, 1988, at which time evidence sufficient to establish pneumoconiosis under one of the four methods set out at Section 718.202(a)(1)-(4) obviated the need to do so under any of the other methods." The Administrative Law Judge properly noted that, since the award of miner's benefits, the Fourth Circuit issued *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000) requiring that

[3] The case file indicates that S.D.J., the now deceased coal miner, had filed a claim on April 12, 1988 (DX 1). A notation, dated May 8, 2003, by a claims examiner indicates that there appears to be a portion of the miner's file which is missing, including the decisions by an Administrative Law Judge and the Benefits Review Board (DX 1). However, Claimant's testimony establishes that the miner had been receiving Federal black lung benefits prior to his death (TR 13). In addition, other documentary evidence confirms that the miner was awarded benefits, citing Administrative Law Judge Thomas M. Burke's Decision and Order awarding benefits, dated November 6, 1989, as affirmed by the Benefits Review Board, in its Decision and Order, dated September 28, 1992 (*See.,*CX 1; CX 10, Deposition Exhibit 1). Since the miner's case is closed, the only matter under consideration herein is the widow's claim (DX 30).

types of evidence be weighed together to determine whether the disease is present. As a result, the Board held that "the issue is not identical to the one previously litigated" and collateral estoppel did not apply.

In the present case, all of the miner's coal mine employment occurred in Pennsylvania (DX 1, 5). Therefore, this case arises under the appellate jurisdiction of the Third Circuit, which also holds that all types of relevant evidence must be weighed together to determine whether a miner suffers from pneumoconiosis. *See, Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22 (3d Cir. 1997). Since the Third Circuit issued its decision in *Williams* after the miner's claim was closed, the current claim is procedurally the same as the one presented in *Collins, supra.* Accordingly, I find that collateral estoppel does not apply.

II. Background

A. Coal Miner and Length of Coal Mine Employment

Claimant testified that the miner worked over twelve calendar years. She initially testified that her husband's last coal mine employment ended in 1987. However, with prompting from counsel, Claimant stated that the miner stopped probably in 1980 or 1981 (TR 13-14). On the miner's application for benefits form, the decedent alleged that he had engaged in coal mine employment for 14 years ending in 1981, when he was laid off (DX 1-1). The District Director found that Claimant worked as a coal miner for 10.54 years during the period from 1946 to November 19, 1982 (DX 23). The parties stipulated, and I find, that Claimant engaged in coal mine employment for at least 10.54 years (TR 6). Taken as a whole, I find that the decedent ceased working as a coal miner in the early 1980's. Moreover, I find that the above-stated discrepancies are inconsequential for the purpose of rendering a decision herein.

B. Date of Filing

Claimant filed her claim for black lung benefits under the Act on September 12, 2002 (DX 3). There is no time limit on the filing of a claim by the survivor of a miner. 20 C.F.R. §725.308(a).

C. Responsible Operator

The parties stipulated, and I find, that Allegheny Mineral Corporation is the properly designated responsible operator in this case, under Subpart G of the Regulations (TR 7).

D. Personal, Employment, and Smoking History

The miner was born on January 28, 1926. He married Claimant on March 21, 1947. They remained married until the miner's death on August 23, 2002. Claimant has no dependents for purposes of possible augmentation of benefits under the Act (DX 1, 3, 10, 11; TR 12).

As stated above, the decedent engaged in coal mine employment for at least 10.54 years ending in the early 1980's. The Employment History form states that the miner worked as a coal loader in deep mines in 1946 to 1950, and, then, worked as "back fill dozer operator" in strip mines from 1975 to 1981 (DX 1). Similarly, Claimant testified that the miner loaded coal with a shovel into cars while working in the coal mines; and, the miner also was a dozer operator at the strip mine (TR 14). Prior to working as a coal miner, the decedent primarily worked for a tire manufacturer for about 24 years (TR 15).

Claimant testified that her husband started having slight breathing difficulty when he was still employed as a coal miner. The miner's condition worsened, and he was given oxygen, inhalers, and other medications for his breathing condition. Claimant stated that the miner took oxygen on a 24-hour basis from 1988 until his death (TR 15-17). Claimant also used a wheelchair due to his breathing condition (TR 19). The miner was treated at Clarion Hospital on several occasions for breathing-related problems, and ultimately passed away there (TR 17).

Claimant acknowledged that the miner had a long cigarette smoking history. She testified that her husband had already been a smoker when they were married in 1947, and that he continued to smoke until early 1988. Claimant noted that her husband had previously tried to quit smoking several times, but relapsed after short periods of about three months before he resumed smoking (TR 18). Claimant testified that she bought the cigarettes for her husband, and that she purchased a carton of cigarettes (*i.e.,* ten packs) about every two weeks (TR 18-19). Based upon the foregoing, Claimant testified that her husband had smoked about 5/7 of a pack per day ending in 1988. However, the medical evidence suggests that Claimant may have understated the miner's actual smoking history. For example, the Clarion Hospital History and Physical report, dated April 23, 1995, states, in pertinent part, that the miner "smoked 1 ½ packs per day, but stopped in 1988." (CX 8). The Clarion Hospital History and Physical report, dated December 19, 1997, states that the miner "has approximately a 50 pack year history of cigarette smoking." (CX 8). While I note that other Clarion Hospital records set forth a lesser smoking history (*e.g.,* the 01-30-96 History and Physical report lists a "25 pack year history" ending in 1988) (CX 8), I find no reason why the miner would have overstated his actual cigarette smoking history. In any event, I find that Claimant had a significant cigarette smoking history, and that the duration of his smoking history far exceeded his coal mine employment history.

III. Medical Evidence

The medical evidence includes various chest x-rays and physicians' opinions, which are summarized below.[4]

A. Chest X-rays

The case file contains numerous descriptive interpretations of various chest x-rays which were administered in conjunction with the miner's treatment for breathing problems (DX 13, 15; CX 7, 8). For example, on August 18, 2002, during the miner's terminal admission at Clarion

[4] The record also contains pulmonary function studies and arterial blood gas tests which support a finding that the miner suffered from a totally disabling pulmonary or respiratory impairment prior to his death. However, total disability is not an element of entitlement in a survivor's claim.

Hospital, a portable chest x-ray was interpreted by Dr. Swayze as showing bullous emphysematous changes and crowding of the vessels in the upper lobes and in the left base, but with no evidence of an infiltrate (CX 8). Such findings do not conform with the classification requirements set forth in §718.102(b). Accordingly, the descriptive x-ray interpretations are accorded little weight.

The record does contain two interpretations which are positive for pneumoconiosis under the classification requirements set forth in §718.102(b); namely, Dr. Schaaf's (1/0) interpretations of chest x-rays, dated March 15, 1997 and December 29, 2001, respectively (CX 5). However, Dr. Schaaf listed the quality of both films as only "3" and noted that they were overexposed (CX 5).[5]

On the other hand, the record includes two interpretations which are negative for pneumoconiosis under the classification requirements set forth in §718.102(b); namely, Dr. Kaplan's (0/0) interpretations of the chest x-rays, dated October 20, 2001 and December 29, 2001, respectively (EX 2, p. 10).[6]

Dr. Kaplan's curriculum vitae reveals that he has been a B-reader since 1981 (EX 2, Deposition Exhibit 1). In contrast, Dr. Schaaf testified in January 2006 that he had only been a B-reader for "about a year." (CX 9, p. 6). However, since they are both B-readers, I find that their radiological credentials are roughly comparable.

In summary, the record contains an equal number of positive and negative x-ray interpretations by similarly qualified B-readers. Accordingly, I find that Claimant has failed to meet his burden of establishing the presence of pneumoconiosis by a preponderance of the x-ray evidence.

B. Physicians' Opinions[7]

The case file contains numerous treatment records and related clinical tests provided by Dr. Robert C. Luderer, who is Board-certified in Internal Medicine (DX 13, 14; CX 7) and Clarion Hospital (DX 15; CX 8). The above-referred records clearly establish that the miner suffered from a severe pulmonary or respiratory impairment in the years preceding his death. Furthermore, the records indicate that the miner had an extensive history of chronic obstructive pulmonary disease, and that he also suffered from repeated bouts of pneumonia. In addition, coal worker's pneumoconiosis is listed on several occasions among various diagnoses.

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[5] Although Dr. Schaaf completed NIOSH x-ray form reports, the record only contains copies of the front page of each report. I take judicial notice that the back of the NIOSH forms describes film quality 3 as follows: "Poor, with some technical defect but still acceptable for classification purposes."

[6] Dr. Kaplan did not specify the film quality of the films. However, if the x-rays are read, then it may be assumed that the films were of acceptable quality. *Auxier v. Director, OWCP*, 8 BLR 1-109 (1985).

[7] Medical reports and/or physicians' testimony which refer to documents not in evidence are deemed to have been redacted. Unless I make a specific finding herein that the redacted data is critical to a physician's ultimate opinion, the redaction of objectionable information will not materially affect the weight I accord such opinion. *See, Harris v. Old Ben Coal Co.*, 23 BLR 1-98, BRB No. 04-0812 BLA (Jan. 27, 2006); *see also, Webber v. Peabody Coal Co.*, 23 BLR 1-123, BRB No. 05-0335 BLA (Jan. 27, 2006)(en banc).

However, the underlying rationale for listing the diagnosis of coal worker's pneumoconiosis is not well-reasoned or well-documented.

For the purpose of this survivor's claim, the most relevant treatment records are those involving the miner's condition during his final hospitalization. The case file establishes that the miner was treated at Clarion Hospital from August 18, 2002 until his death on August 23, 2002 (CX 8). The full text of the Clarion Hospital Discharge Summary, dated August 23, 2002, signed by Dr. Robert C. Luderer, is as follows:

FINAL DIAGNOSES: Respiratory failure.
Chronic obstructive pulmonary disease.[8]
Congestive heart failure.

This white male was admitted with the chief complaint of marked increasing cough and shortness of breath. He has known chronic obstructive pulmonary disease. His disease condition has progressed. He is at home now. He is totally dependent upon his wife to do everything for him. He could not even bathe himself now without becoming severely dyspneic. His disease has generally progressed over the past several years. A chest x-ray showed bullous emphysema changes. No infiltrate was seen. The heart was small and vertical. He was admitted to the hospital. He was placed on intravenous corticosteroids and breathing treatments.

Arterial blood gases showed carbon dioxide retention and hypercarpia. His oxygen level was adjusted. He was very dyspneic and short of breath. He did not want to be placed on a volume ventilator. He did not want BiPAP or CPAP. He requested and the family requested comfort measures only. He was subsequently, in spite of aggressive medical therapy, placed on a morphine drip. A beta natriuretic level was elevated, showing coexisting congestive heart failure and this was treated with diuretics. He was eventually placed on intravenous Lasix and ultra nebulizer treatments with morphine and eventually placed to a morphine drip and he expired at 6:35 a.m. on the morning of the 23rd.

He had no laboratory studies since the 21st at the family's request. At that time, his pH was 7.26, PCO2 was 69 and PO2 was 124. Sodium was 135 and potassium 5.3. Creatinine was 1.8 and BUN was 70. Glucose was 129. White blood count was 10,400, hemoglobin 13.8 and 44.9% hematocrit and platelets were 277,000. B type natriuretic P level was 159. Legionella antibody titer was pending. On admission, his pH was 7.25, PCO2 70 and PO2 62. Troponins were negative. When he first came, we did place him on BiPAP and he did respond to that, but then requested to have it removed and not replace it.

(CX 8).

The miner's death certificate, which was signed by Dr. Luderer, states that the miner died on August 23, 2002, at age 76. The immediate cause of death was reported as "Respiratory

[8] The Discharge Summary in evidence contains a handwritten notation next to the typewritten words "Chronic obstructive pulmonary disease," which appears to be "omit" (CX 8). However, the text of the Discharge Summary clearly refers to "chronic obstructive pulmonary disease." (CX 8). Therefore, I accord the handwritten notation little weight.

Failure" due to "Chronic Obstructive Lung Disease." In addition, Dr. Luderer listed "Congestive Heart Failure" under the heading – "Other significant conditions contributing to death, but not resulting in the underlying cause given in PART I" (*i.e.,* not resulting in the immediate cause). (DX 11).

The other relevant medical opinion evidence consists of the reports and/or deposition testimony of Drs. Fino (EX 1), Schaaf (CX 1, 9), Begley (CX 3, 10), and Kaplan (EX 2), respectively.

Dr. Gregory J. Fino, a B-reader who is Board-certified in Internal Medicine and Pulmonary Disease (EX 1, Deposition Exhibit 1), issued a report, dated April 30, 2003, in which he reviewed the available evidence, including the miner's treatment records (EX 1, Deposition Exhibit 2).[9] Furthermore, Dr. Fino charted the reported occupational and smoking histories. In summary, Dr. Fino stated:

IV. Discussion

This man had a significant smoking history, as illustrated in the above table. It is the type of smoking history which could account for all of this man's respiratory symptoms, lung function abnormalities, and blood gas abnormalities.

He worked about 13 years in the mines. Although this is sufficient to cause coal worker's pneumoconiosis, the length of the employment makes it unlikely. This type of history could cause significant silicosis and fibrosis if he were employed as a driller or had significant quartz exposure. If there were pulmonary fibrosis on the chest films and a restrictive pattern on the lung function tests, one might arrive at a clinical finding of significant silicosis or fibrosis. However, there is nothing to suggest that finding in this case. What is seen is an obstructive abnormality with significant blood gas abnormalities indicating both emphysema and chronic obstructive bronchitis. Although coal worker's pneumoconiosis can cause these types of conditions, it would be unlikely considering his mining history. Also, the repeated bouts of pneumonia are consistent with smoking, but not coal worker's pneumoconiosis.

From a functional standpoint, this man's pulmonary system was very abnormal. He did not retain the physiologic capacity, from a respiratory standpoint, to perform all of the requirements of his last job. There are two potential risk factors for this disability: coal mine dust exposure and smoking. In this instance, the clinical information is consistent with a smoking-related disability. Even if his coal mine employment contributed to the obstruction, the loss in the FEV1 would be of no clinical significance. If we gave back to him that amount of FEV1, this man would still have been disabled. This medical estimate of loss in FEV1 in working miners was summarized in the 1995 NIOSH document. This man would have been as disabled had he never stepped foot in the mines.

[9] As previously noted, medical reports and/or physicians' testimony which refer to documents not in evidence are deemed to have been redacted. Thus, Dr. Fino's references to clinical data in excess of the evidentiary limitations are excluded. Nevertheless, as discussed above, I find that Dr. Fino's opinion is reasoned and documented.

This man died as a result of lung disease due to smoking; coal mine dust inhalation played no role in his death.

The above information has been reviewed, and it is my opinion that this man did not suffer from pneumoconiosis. He was disabled and died as a result of cigarette smoking-induced lung disease. Coal worker's pneumoconiosis played no role and he would have been as disabled and died as and when he did had he never stepped foot in the mines.

V. Conclusions

1. There is insufficient objective evidence to justify a diagnosis of clinical or legal pneumoconiosis.

2. There was a disabling respiratory impairment present.

3. From a respiratory standpoint, this man was totally disabled from returning to his last mining job or a job requiring similar effort.

4. Even if I were to assume that this man had clinical or legal pneumoconiosis, it had not contributed to his disability or his death. He would have been as disabled had he never stepped foot in the mines. Coal mine dust inhalation did not hasten his death.

(EX 1, Deposition Exhibit 2, pp. 29-30).

Dr. Fino testified at deposition held on February 23, 2004 (EX 1). He cited the decedent's relatively short coal mine employment history, the miner's more extensive smoking history, and, the clinical test results, in conjunction with medical literature which quantify the average loss of FEV1 based upon the number of years of coal mine dust exposure. Based upon the foregoing, Dr. Fino opined that the miner did not have clinical or legal pneumoconiosis; and, that the miner's coal dust inhalation did not play a significant contributing role in the miner's total disability, nor did it cause, contribute, or hasten the miner's death (EX 1, pp. 9-18). On cross-examination, Dr. Fino acknowledged that, if the miner had pneumoconiosis, and the disease was a significant contributing factor in his disability, then, under that hypothetical, he would find that pneumoconiosis contributed to the miner's pulmonary death (EX 1, pp. 19-20).

Dr. John T. Schaaf, a B-reader who is Board-certified in Internal Medicine, Pulmonary Disease, and Critical Care Medicine (CX 9, pp. 3-7; CX 2), issued a report, dated October 25, 2004, in which he cited various medical data, as well as DOL rulings awarding benefits.[10] However, Dr. Schaaf's analysis of such evidence was rather cursory. In conclusion, Dr. Schaaf answered two questions posed by Claimant's counsel, as follows:

Did [the miner] acquire coal workers' pneumoconiosis during his life?

[10] Dr. Schaaf's references to clinical data in excess of the evidentiary limitations are excluded. However, that is not the primary basis for my finding that Dr. Schaaf's opinion is unpersuasive.

The answer is yes. He did acquire coal workers' pneumoconiosis during his life. His coal workers' pneumoconiosis is manifest as an abnormal chest x-ray on a number of occasions as well as chronic obstructive pulmonary disease. Significant coal dust exposure based on the available records and his disabling pulmonary disease was due in part to his coal mine employment. Smoking was also a contributing factor.

Did coal workers' pneumoconiosis cause, substantially contribute to or accelerate the death of [the miner]?

The answer to this question is also yes. He has (sic) severe disabling pulmonary disease due to coal workers' pneumoconiosis and he eventually died from this condition a state of progressive respiratory failure. While his smoking history was also no doubt contributory, it is my opinion that his respiratory failure and ultimate death were substantially contributed to by his coal workers' pneumoconiosis.

(CX 1, p. 4).

Dr. Schaaf testified at deposition held on January 27, 2006 (CX 9). On direct examination, Dr. Schaaf cited the miner's coal mine employment history, positive x-ray interpretations for pneumoconiosis, complaints of breathlessness, and the results of pulmonary function tests and arterial blood gas studies, as well as medical records, and reiterated that the miner had a pulmonary disability due to pneumoconiosis (CX 9, pp. 7-14). Furthermore, Dr. Schaaf also reiterated that, in his opinion, coal workers' pneumoconiosis substantially contributed and hastened his death. Dr. Schaaf testified that pneumoconiosis "induced chronic obstructive airways disease and chronic hypoxemia which were the causes of his death, and that was supplemented by his development of cor pulmonale." (CX 9, p. 31). However, Dr. Schaaf also acknowledged that the miner's smoking history of at least 30-pack years is sufficient to induce pulmonary dysfunction and impairment (CX 9, p. 15). Moreover, on cross-examination, Dr. Schaaf acknowledged that his diagnosis of coal workers' pneumoconiosis was based on positive chest x-ray interpretations (CX 9, p. 33). Furthermore, on cross-examination, Dr. Schaaf conceded that, in every [survivor's] case that an individual had a significant smoking history and radiographic evidence of coal worker's pneumoconiosis, he would find that coal worker's pneumoconiosis would have been a substantial factor in death (CX 9, p. 45). However, Dr. Schaaf sought to qualify his opinion on re-direct examination (CX 9, pp. 48-52). In summary, Dr. Schaaf's opined that the miner had two possible etiologies; namely, coal mine dust and cigarette smoking. Notwithstanding the relative levels of exposure, in view of the positive x-ray evidence for pneumoconiosis, Dr. Schaaf concluded that both etiologies played substantial contributing roles in the miner's pulmonary disability and death (CX 9).

Dr. Christopher J. Begley, who is Board-certified in Internal Medicine, Pulmonary Medicine, and Critical Care Medicine (CX 4), issued a report, dated August 29, 2005 (CX 3). In addition, Dr. Begley testified at deposition on February 22, 2006 (CX 10).[11] Dr. Begley's somewhat cursory report states that he reviewed "a variety of records" that were provided by

[11] Dr. Begley's references to clinical data in excess of the evidentiary limitations are excluded. However, that is not the primary basis for my finding that Dr. Begley's opinion is unpersuasive.

Claimant's counsel under cover letter, dated May 12, 2005. The referenced letter is included in the record as a deposition exhibit (CX 10, Deposition Exhibit 1).

At the conclusion of Dr. Begley's 1+ page report, dated August 29, 2005, he stated, in pertinent part:

It is my opinion that within a reasonable degree of medical certainty that coal workers pneumoconiosis was a significant contributing factor to [the miner's] untimely death. [The miner's] death certificate which was signed on August 27, 2002, reflects that the cause of his death was respiratory failure. Simple coal workers pneumoconiosis is known to cause pulmonary impairment a well as progressive pulmonary disease after the cessation of exposure to coal dust. While [the miner] did have a history of cigarette use, as a significant contributing cause to his pulmonary impairment, it was also found that simple pneumoconiosis was also a significant contributing factor to his pulmonary impairment. Therefore, it is my opinion that within a reasonable degree of medical certainty that his simple coal workers pneumoconiosis which was a significant contributing factor to his pulmonary impairment also significantly contributed to his respiratory failure which led to his ultimate demise.

(CX 3).

In his deposition testimony, Dr. Begley reiterated the above-stated conclusion, stating that coal worker's pneumoconiosis was a "significant contributing factor" in the miner's "untimely death" (CX 10, p. 10). Furthermore, Dr. Begley explained the "mechanics of death" and the basis of his opinion, as follows:

Coal workers' pneumoconiosis can cause permanent lung damage. We know that this gentleman had significant pulmonary impairment by pulmonary function test criteria and by arterial blood gas criteria. In the setting of significant pulmonary impairment, he was not adequately able to – he was not adequately able to tolerate stress which – or infection, which precipitated his untimely respiratory failure death.

(CX 10, p. 14).

On cross-examination, Dr. Begley stated that his finding of pneumoconiosis is predicated upon positive chest x-ray readings by other physicians, an appropriate history of exposure, and the history and physicals obtained by other physicians (CX 10, pp. 15-16). Furthermore, on re-direct examination, Dr. Begley stated that his diagnosis of occupational pneumoconiosis is based upon "an appropriate history, appropriate symptoms, appropriate laboratory studies, besides the chest x-ray." (CX 10, pp. 22-23).

Dr. Peter D. Kaplan, a B-reader who is Board-certified in Internal Medicine, Pulmonary Medicine, and Critical Care Medicine (EX 2, Deposition Exhibit 1), testified at deposition on February 13, 2006 (EX 2).[12] Dr. Kaplan summarized the miner's treatment records, employment

[12] Dr. Kaplan's references to clinical data in excess of the evidentiary limitations are excluded. Nevertheless, as discussed above, I find that Dr. Kaplan's opinion is reasoned and documented.

history and smoking history. Furthermore, Dr. Kaplan cited various clinical test results, including his own x-ray rereadings of two films, which were negative for pneumoconiosis. Based upon the foregoing, Dr. Kaplan opined that the miner suffered from chronic obstructive pulmonary disease due to cigarette smoking (EX 2, pp. 7-18). Furthermore, Dr. Kaplan specified that he is able to differentiate from several potential causes in this case, stating, in pertinent part:

He [the miner] had a classic presentation for COPD. Sometimes we see COPD developing in asthmatics where they go through a phase of reactive airway disease, and then it becomes more fixed and emerges into COPD. This is not the story that we have here. Here he has a classic cigarette-induced case of COPD.

Now, sometimes we see airflow obstruction associated, for example with advanced coal workers' pneumoconiosis or silicosis, but that's only in advanced cases where we see often times complicated pneumoconiosis, and that was not the situation in this case.

(EX 2, p. 19).

Accordingly, Dr. Kaplan opined that the miner's death was related to cigarette smoking, and that pneumoconiosis or coal mine dust exposure did not play a role in the miner's death (EX 2, p. 20). On cross-examination, Dr. Kaplan stated that, in his opinion, "it's awfully hard" to diagnose a coal-dust-related disease or disability without a positive chest x-ray (EX 2, pp. 24-25). Dr. Kaplan did not directly respond to Claimant counsel's questions regarding whether his opinion would change with respect to the cause of death, if he assumed that the miner suffered from pneumoconiosis and that the disease contributed to his disability (EX 2, pp. 25-28). However, on re-direct examination, Dr. Kaplan reiterated that coal mine dust exposure did not contribute at all to the miner's death (EX 2, pp. 28-29).

VI. Pneumoconiosis

Section 718.202 provides four means by which pneumoconiosis may be established. Under §718.202(a)(1), a finding of pneumoconiosis may be made on the basis of the x-ray evidence. As stated above, the record contains two positive (1/0) interpretations for pneumoconiosis by Dr. Schaaf, a recently certified B-reader, who found the films were of poor quality, but acceptable for classification purposes (CX 5; CX 9, p. 6). On the other hand, Dr. Kaplan, a B-reader since 1981, interpreted two films as negative for pneumoconiosis (EX 2, p. 10). Among the conflicting readings are those of a recent film, dated December 29, 2001. Since similarly qualified B-readers reached opposite conclusions, I find that Claimant has failed to meet his burden of establishing the existence of pneumoconiosis under §718.202(a)(1).

Under §718.202(a)(2), a finding of pneumoconiosis may be made on the basis of biopsy or autopsy evidence. Since the record does not contain any such evidence, this subsection is not applicable.

Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found applicable. In the instant case, the presumption of §718.304 does not apply because there is no evidence in the record of complicated

pneumoconiosis. Section 718.305 is inapplicable to claims filed after January 1, 1982. Finally, the presumption of §718.306 does not apply to cases where the miner died after March 1, 1978. Therefore, the Claimant cannot establish pneumoconiosis under §718.202(a)(3).

Under §718.202(a)(4), a determination of the existence of pneumoconiosis may be made if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in §718.201. Pneumoconiosis is defined in §718.201 means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both "Clinical Pneumoconiosis" and "Legal Pneumoconiosis." *See* 20 C.F.R. §718.202(a)(1) and (2).

As stated above, the treatment records and related clinical tests provided by Dr. Robert C. Luderer (DX 13, 14; CX 7) and Clarion Hospital (DX 15; CX 8) clearly establish that the miner suffered from a disabling pulmonary impairment, and that he died due to his respiratory or pulmonary condition. Furthermore, the records include some references to coal worker's pneumoconiosis among various diagnoses. However, the underlying rationale for listing the diagnosis of coal worker's pneumoconiosis is not well-reasoned or well-documented. Moreover, coal worker's pneumoconiosis is not listed as a diagnosed condition on the terminal hospital discharge summary. Similarly, the miner's death certificate, signed by Dr. Luderer, does not mention pneumoconiosis, but also indicates that the miner died a respiratory death due to chronic obstructive lung disease (DX 11). Accordingly, if the miner's chronic obstructive lung disease arose out of coal mine employment, such a finding would meet the definition of "legal pneumoconiosis." 20 C.F.R. §718.201(a)(2). However, the death certificate does not specify the etiology of the miner's chronic obstructive lung disease. Moreover, the death certificate is neither well-reasoned nor well-documented. Accordingly, the crux of this case rests on the relative weight, I accord to the medical opinions of Drs. Fino (EX 1), Schaaf (CX 1, 9), Begley (CX 3, 10), and Kaplan (EX 2), respectively.

Drs. Schaaf, Begley and Kaplan are all Board-certified in Critical Care Medicine, while Dr. Fino is not. However, all four of the above-named physicians are Board-certified pulmonary specialists. Since this matter involves a pulmonary death, I find that Dr. Fino's lack of Board-certification in Critical Care Medicine is inconsequential. Accordingly, I find that the relative qualifications of all four physicians are similar. Furthermore, there is a consensus among the physicians that the miner suffered from chronic obstructive lung disease, which was disabling during his lifetime and caused his death. The essence of this case is whether the miner's coal mine dust exposure contributed to chronic obstructive pulmonary disease or respiratory failure, and, thereby, also played a role in the miner's death.

If the decision in the miner's claim were controlling in this survivor's case, I would adopt the position of Drs. Schaaf and Begley, who diagnosed pneumoconiosis and found that the miner's death was attributable thereto. Furthermore, the inability of Drs. Schaaf and Begley to apportion the effects of coal mine employment and cigarette smoking does not make their opinions flawed, because such a particularized finding is not necessary. *See, e.g., Consolidation Coal Co. v. Director, OWCP [Williams]*, ___ F.3d ___, Case No. 05-2108 (4th Cir. July 13, 2006). However, as stated above, the award of benefits in the miner's claim is *not* controlling.

Furthermore, the burden rests on the Claimant to establish all of the necessary elements of entitlement by a preponderance of the evidence.

In the present case, Claimant has not established the presence of clinical pneumoconiosis radiologically. Although Drs. Schaaf and Begley cited other factors in diagnosing pneumoconiosis, such as history, symptoms, clinical test results, and/or other physicians' findings, I find that their diagnosis was primarily predicated on questionable positive x-ray evidence. More importantly, I find that the opinions of Drs. Fino and Kaplan are better reasoned and documented because their analyses are more thorough and more consistent with the miner's history. As stated above, the miner only claimed 14 years of coal mine employment ending in 1981, when he was laid off; and, the parties stipulated that he worked as a coal miner for at least 10.54 years. Furthermore, the vast majority of the miner's coal mine employment was spent in surface mining. In contrast, Claimant acknowledged that the miner was already smoking in 1947, when they were married, and that he continued to smoke until 1988. Moreover, while Claimant testified that she purchased cigarettes for her husband which corresponded to 5/7 pack per day, some of the hospital records listed the miner's smoking habit as 1 ½ packs per day and as much as a 50 pack year history. Therefore, I find that the decedent's mining history is dwarfed by his cigarette smoking history. In view of the foregoing, I accord greater weight to the opinions of Drs. Fino and Kaplan than those of Drs. Schaaf and Begley. Accordingly, I find that Claimant has failed to establish pneumoconiosis under §718.202(a)(4), or by any other means.

I have also weighed all the relevant evidence together under 20 C.F.R. §718.202(a) to determine whether the miner suffered from pneumoconiosis, as defined in §718.201. In summary, the x-ray evidence and medical opinion evidence fail to establish (clinical or legal) pneumoconiosis. Therefore, I find that pneumoconiosis has not been established under 20 C.F.R. §718.202(a). *See, Penn Allegheny Coal Co. v. Williams,* supra; *Island Creek Coal Co. v. Compton*, *supra*.

VII. Causal Relationship

Since Claimant failed to establish the presence of (clinical or legal) pneumoconiosis, she also cannot establish that the disease arose from his coal mine employment. If Claimant had established the existence of pneumoconiosis, however, she would be entitled to the rebuttable presumption that the disease arose from his more than ten years of coal mine employment. 20 C.F.R. §718.203.

VIII. Death due to Pneumoconiosis

For the reasons outlined above, I credit the opinions of Drs. Fino and Kaplan over those of Drs. Schaaf and Begley. Accordingly, I find that Claimant has failed to establish death due to pneumoconiosis under §718.205(c).

IX. Conclusion

Having considered the relevant evidence, I find that Claimant has not established the presence of (clinical or legal) pneumoconiosis and/or that the disease caused, substantially contributed to, or hastened the miner's death. Accordingly, Claimant is not eligible for benefits under the Act and regulations.

ORDER

It is ordered that the claim of L.J., surviving spouse of S.D.J., a deceased miner, for benefits under the Black Lung Benefits Act is hereby **DENIED.**

A

RICHARD A. MORGAN
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with this Decision and Order you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which this Decision and Order is filed with the district director's office. *See* 20 C.F.R. §§725.458 and 725.459. The address of the Board is: ***Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, D.C. 20013-7601.*** Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. §802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor for Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20210. *See* 20 C.F.R. §725.481.

If an appeal is not timely filed with the Board, this Decision and Order will become the final order of the Secretary of Labor pursuant to 20 C.F.R. §725.479(a).

Notice of public hearing: By statute and regulation, black lung hearings are open to the public. 30 U.S.C. § 932(a) (incorporating 33 U.S.C. § 923(b)); 20 C.F.R. § 725.464. Under e-FOIA, final agency decisions are required to be made available via telecommunications, which under current technology is accomplished by posting on an agency web site. *See* 5 U.S.C. § 552(a)(2)(E). *See also* Privacy Act of 1974; Publication of Routine Uses, 67 Fed. Reg. 16815 (2002) (DOL/OALJ-2). Although 20 C.F.R. §

725.477(b) requires decisions to contain the names of the parties, it is the policy of the Department of Labor to avoid use of the Claimant's name in case-related documents that are posted to a Department of Labor web site. Thus, the final ALJ decision will be referenced by the Claimant's initials in the caption and only refer to the Claimant by the term "Claimant" in the body of the decision. If an appeal is taken to the Benefits Review Board, it will follow the same policy. This policy does not mean that the Claimant's name or the fact that the Claimant has a case pending before an ALJ is a secret.